I

106TH CONGRESS
1ST SESSION

H. R. 2012

To amend title XVIII of the Social Security Act to provide for coverage of outpatient prescription drugs under the Medicare Program.

IN THE HOUSE OF REPRESENTATIVES

JUNE 7, 1999

Mr. DEUTSCH (for himself and Mr. WEXLER) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to provide for coverage of outpatient prescription drugs under the Medicare Program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Prescription Drug Benefit Act of 1999''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. MEDICARE COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (S);

(2) by striking the period at the end of subparagraph (T) and inserting ''; and''; and

(3) by adding at the end the following:

''(U) covered outpatient drugs (as defined in subsection (i)(1) of section 1849) pursuant to the procedures established under such section;''.

(b) PAYMENT.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(1) by striking ''and (S)'' and inserting ''(S)''; and

(2) by striking the semicolon at the end and inserting the following: '', and (T) with respect to covered outpatient drugs (as defined in subsection (i)(1) of section 1849), the amounts paid shall be the

amounts established by the Secretary pursuant to such section;''.

SEC. 3. SELECTION OF ENTITIES TO PROVIDE OUTPATIENT DRUG BENEFIT.

Part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) is amended by adding at the end the following:

''SEC. 1849. SELECTION OF ENTITIES TO PROVIDE OUTPATIENT DRUG BENEFIT.

''(a) ESTABLISHMENT OF BIDDING PROCESS.—

''(1) IN GENERAL.—The Secretary shall establish procedures under which the Secretary accepts bids from eligible entities and awards contracts to such entities in order to provide covered outpatient drugs to eligible beneficiaries in an area. Such contracts may be awarded based on shared risk, capitation, or performance.

''(2) AREA.—

''(A) REGIONAL BASIS.—The contract entered into between the Secretary and an eligible entity shall require the eligible entity to provide covered outpatient drugs on a regional basis.

''(B) DETERMINATION.—In determining coverage areas under this section, the Secretary shall take into account the number of eligible

beneficiaries in an area in order to encourage participation by eligible entities.

''(3) SUBMISSION OF BIDS.—Each eligible entity desiring to provide covered outpatient drugs under this section shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require. Such bids shall include the amount the eligible entity will charge enrollees under subsection (e)(2) for covered outpatient drugs under the contract.

''(4) ACCESS.—The Secretary shall ensure that—

''(A) an eligible entity complies with the access requirements described in subsection (f)(5);

''(B) if an eligible entity employs formularies pursuant to subsection (f)(6)(A), such entity complies with the requirements of subsection (f)(6)(B); and

''(C) an eligible entity makes available to each beneficiary covered under the contract the full scope of benefits required under paragraph (5).

''(5) SCOPE OF BENEFITS.—The Secretary shall ensure that all covered outpatient drugs that are reasonable and necessary to prevent or slow the deterioration of, and improve or maintain, the health of eligible beneficiaries are offered under a contract entered into under this section.

''(6) NUMBER OF CONTRACTS.—The Secretary shall, consistent with the requirements of this section and the goal of containing medicare program costs, award at least 2 contracts in an area, unless only 1 bidding entity meets the minimum standards specified under this section and by the Secretary.

''(7) DURATION OF CONTRACTS.—Each contract under this section shall be for a term of at least 2 years but not more than 5 years, as determined by the Secretary.

''(8) BENCHMARK FOR CONTRACTS.—The Secretary shall not enter into a contract with an eligible entity under this section unless the Secretary determines that the average cost (excluding any cost-sharing) for all covered outpatient drugs provided to beneficiaries under the contract is comparable to the average cost charged (exclusive of any cost-sharing) by large private sector purchasers for such drugs.

''(b) ENROLLMENT.—

''(1) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary shall make an election to enroll with any eligible entity that has been awarded a contract under this section and serves the geographic area in which the beneficiary resides. In establishing such process, the Secretary shall use rules similar to the rules for enrollment and disenrollment with a Medicare+Choice plan under section 1851.

''(2) REQUIREMENT OF ENROLLMENT.—Excluding an eligible beneficiary enrolled in a group health plan described in section 4 of the Medicare Prescription Drug Benefit Act of 1999, an eligible beneficiary not enrolled in a Medicare+Choice plan under part C must enroll with an eligible entity under this section in order to be eligible to receive covered outpatient drugs under this title.

''(3) ENROLLMENT IN ABSENCE OF ELECTION BY ELIGIBLE BENEFICIARY.—In the case of an eligible beneficiary that fails to make an election pursuant to paragraph (1), the Secretary shall provide, pursuant to procedures developed by the Secretary, for the enrollment of such beneficiary with an eligible entity that has a contract under this section that covers the area in which such beneficiary resides.

''(4) AREAS NOT COVERED BY CONTRACTS.—The Secretary shall develop procedures for the provision of covered outpatient drugs under this title to eligible beneficiaries that reside in an area that is not covered by any contract under this section.

''(5) BENEFICIARIES RESIDING IN DIFFERENT LOCATIONS.—The Secretary shall develop procedures to ensure that an eligible beneficiary that resides in different regions in a year is provided benefits under this section throughout the entire year.

''(c) PROVIDING INFORMATION TO BENEFICIARIES.—The Secretary shall provide for activities under this section to broadly disseminate information to medicare beneficiaries on the coverage provided under this section. Such activities shall be similar to the activities performed by the Secretary under section 1851(d).

''(d) PAYMENTS TO ELIGIBLE ENTITIES.—The Secretary shall establish procedures for making payments to an eligible entity under a contract.

''(e) COST-SHARING.—

''(1) DEDUCTIBLE.—Benefits under this section shall not begin until the eligible beneficiary has met a deductible equal to—

''(A) $200 for 2000; or

''(B) for a subsequent year the amount of the deductible under subparagraph (A) or this subparagraph for the previous year increased by a factor that reflects the annual rate of change in the per capita cost of prescription drugs for beneficiaries under this title.

If any dollar amount determined under subparagraph (B) for a year is not a multiple of $5, such dollar amount shall be rounded to the nearest multiple of $5.

''(2) COPAYMENT.—

''(A) IN GENERAL.—Subject to subparagraph (B), the eligible beneficiary shall be responsible for making payments in an amount not greater than 20 percent of the cost (as stated in the contract) of any covered outpatient drug that is provided to the beneficiary. Pursuant to subsection (a)(4)(B), an eligible entity may reduce the payment amount that an eligible beneficiary is responsible for making to the entity.

''(B) BASIC BENEFIT.—If the aggregate amount of covered outpatient drugs provided to an eligible beneficiary under this section for any calendar year (based on the cost of covered out-

patient drugs stated in the contract) exceeds $5,200—

"(i) the beneficiary may continue to purchase covered outpatient drugs under the contract based on the contract price, but

"(ii) the copayment under subparagraph (A) shall be 100 percent.

"(C) INFLATION ADJUSTMENT.—

"(i) IN GENERAL.—In the case of any calendar year beginning after 2000, each of the dollar amounts in subparagraph (B) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) an adjustment, as determined by the Secretary, for changes in the per capita cost of prescription drugs for beneficiaries under this title.

"(ii) ROUNDING.—If any dollar amount after being increased under clause (i) is not a multiple of $10, such dollar amount shall be rounded to the nearest multiple of $10.

''(f) CONDITIONS FOR AWARDING CONTRACT.—The Secretary shall not award a contract to an eligible entity under subsection (a) unless the Secretary finds that the eligible entity is in compliance with such terms and conditions as the Secretary shall specify, including the following:

''(1) QUALITY AND FINANCIAL STANDARDS.—The eligible entity meets quality and financial standards specified by the Secretary.

''(2) INFORMATION.—The eligible entity provides the Secretary with information that the Secretary determines is necessary in order to carry out the bidding process under this section, including data needed to implement subsection (a)(8) and data regarding utilization, expenditures, and costs.

''(3) EDUCATION.—The eligible entity establishes educational programs that meet the criteria established by the Secretary pursuant to subsection (g)(1).

''(4) PROCEDURES TO ENSURE PROPER UTILIZATION AND TO AVOID ADVERSE DRUG REACTIONS.—The eligible entity has in place procedures to ensure the—

"(A) appropriate utilization by eligible beneficiaries of the benefits to be provided under the contract; and

"(B) avoidance of adverse drug reactions among eligible beneficiaries enrolled with the entity.

"(5) ACCESS.—The eligible entity ensures that the covered outpatient drugs are accessible and convenient to eligible beneficiaries covered under the contract, including by offering the services in the following manner:

"(A) SERVICES DURING EMERGENCIES.—The offering of services 24 hours a day and 7 days a week for emergencies.

"(B) CONTRACTS WITH RETAIL PHARMACIES.—The offering of services—

"(i) at a sufficient (as determined by the Secretary) number of retail pharmacies; and

"(ii) to the extent feasible, at retail pharmacies located throughout the eligible entity's service area.

"(6) RULES RELATING TO PROVISION OF BENEFITS.—

''(A) PROVISION OF BENEFITS.—In providing benefits under a contract under this section, an eligible entity may—

''(i) employ mechanisms to provide benefits economically, including the use of—

''(I) formularies (pursuant to subparagraph (B));

''(II) alternative methods of distribution; and

''(III) generic drug substitution; and

''(ii) use incentives to encourage eligible beneficiaries to select cost-effective drugs or less costly means of receiving drugs.

''(B) FORMULARIES.—If an eligible entity uses a formulary to contain costs under this Act—

''(i) the eligible entity shall—

''(I) ensure participation of practicing physicians and pharmacists in the development of the formulary;

''(II) include in the formulary at least 1 drug from each therapeutic class;

''(III) provide for coverage of otherwise covered non-formulary drugs when recommended by prescribing providers; and

''(IV) disclose to current and prospective beneficiaries and to providers in the service area the nature of the formulary restrictions, including information regarding the drugs included in the formulary, copayment amounts, and any difference in the cost-sharing for different types of drugs; but

''(ii) nothing shall preclude an entity from—

''(I) requiring higher cost-sharing for drugs provided under clause (i)(III), subject to limits established in subsection (e)(2)(A), except that an entity shall provide for coverage of a nonformulary drug on the same basis as a drug within the formulary if such

nonformulary drug is determined by the prescribing provider to be medically indicated;

"(II) educating prescribing providers, pharmacists, and beneficiaries about medical and cost benefits of formulary products; and

"(III) requesting prescribing providers to consider a formulary product prior to dispensing of a nonformulary drug, as long as such request does not unduly delay the provision of the drug.

"(7) CLINICAL QUALITY STANDARDS.—

"(A) REQUIREMENT.—The eligible entity shall comply with clinical quality standards as determined by the Secretary.

"(B) DEVELOPMENT OF STANDARDS.—The Secretary, in consultation with appropriate medical specialty societies, shall develop clinical quality standards that are applicable to eligible entities. Such standards shall be based on current standards of care.

"(8) PROCEDURES REGARDING DENIALS OF CARE.—The eligible entity has in place procedures to ensure—

"(A) the timely review and resolution of denials of care and complaints (including those regarding the use of formularies under paragraph (6)) by enrollees, or providers, pharmacists, and other individuals acting on behalf of such individual (with the individual's consent) in accordance with requirements (as established by the Secretary) that are comparable to such requirements for Medicare+Choice organizations under part C; and

"(B) that beneficiaries are provided with information regarding the appeals procedures under this section at the time of enrollment.

"(g) EDUCATIONAL REQUIREMENTS TO ENSURE APPROPRIATE UTILIZATION.—

"(1) ESTABLISHMENT OF PROGRAM CRITERIA.—The Secretary shall establish a model for comprehensive educational programs in order to assure the appropriate—

"(A) prescribing and dispensing of covered outpatient drugs under this section; and

''(B) use of such drugs by eligible beneficiaries.

''(2) ELEMENTS OF MODEL.—The model established under paragraph (1) shall include the following elements:

''(A) On-line prospective review available 24 hours a day and 7 days a week in order to evaluate each prescription for drug therapy problems due to duplication, interaction, or incorrect dosage or duration of therapy.

''(B) Consistent with State law, guidelines for counseling eligible beneficiaries enrolled under a contract under this section regarding—

''(i) the proper use of prescribed covered outpatient drugs; and

''(ii) interactions and contra-indications.

''(C) Where appropriate and non-duplicative, methods to identify and educate providers, pharmacists, and eligible beneficiaries regarding—

''(i) instances or patterns concerning the unnecessary or inappropriate prescribing or dispensing of covered outpatient drugs;

"(ii) instances or patterns of substandard care;

"(iii) potential adverse reactions to covered outpatient drugs;

"(iv) inappropriate use of antibiotics;

"(v) appropriate use of generic products; and

"(vi) the importance of using covered outpatient drugs in accordance with the instruction of prescribing providers.

"(h) PROTECTION OF PATIENT CONFIDENTIALITY.—Insofar as an eligible organization maintains individually identifiable medical records or other health information regarding enrollees under a contract entered into under this section, the organization shall—

"(1) safeguard the privacy of any individually identifiable enrollee information;

"(2) maintain such records and information in a manner that is accurate and timely; and

"(3) assure timely access of such enrollees to such records and information.

"(i) DEFINITIONS.—In this section:

"(1) COVERED OUTPATIENT DRUG.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered outpatient drug' means any of the following products:

"(i) A drug which may be dispensed only upon prescription, and—

"(I) which is approved for safety and effectiveness as a prescription drug under section 505 of the Federal Food, Drug, and Cosmetic Act;

"(II)(aa) which was commercially used or sold in the United States before the date of enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (bb) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a)

of such Act to enforce section 502(f) or 505(a) of such Act; or

''(III)(aa) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (bb) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

''(ii) A biological product which—

''(I) may only be dispensed upon prescription;

''(II) is licensed under section 351 of the Public Health Service Act; and

''(III) is produced at an establishment licensed under such section to produce such product.

''(iii) Insulin approved under appropriate Federal law.

''(iv) A prescribed drug or biological product that would meet the requirements of clause (i) or (ii) but that is available over-the-counter in addition to being available upon prescription.

''(B) EXCLUSION.—The term 'covered outpatient drug' does not include any product—

''(i) except as provided in subparagraph (A)(iv), which may be distributed to individuals without a prescription;

''(ii) when furnished as part of, or as incident to, a diagnostic service or any other item or service for which payment may be made under this title;

''(iii) that was covered under this title on the day before the date of enactment of the Medicare Prescription Drug Benefit Act of 1999; or

''(iv) that is a therapeutically equivalent replacement for a product described in clause (ii) or (iii), as determined by the Secretary.

''(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual that is enrolled under part B of this title.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any entity that the Secretary determines to be appropriate, including—

''(A) pharmaceutical benefit management companies;

''(B) wholesale and retail pharmacist delivery systems;

''(C) insurers;

''(D) other entities; or

''(E) any combination of the entities described in subparagraphs (A) through (D).''.

SEC. 4. OPTIONAL COVERAGE FOR CERTAIN BENEFICIARIES.

(a) IN GENERAL.—If drug coverage under a group health plan that provides health insurance coverage for retirees is equivalent to or greater than the coverage provided under section 1849 of the Social Security Act (as added by section 3), beneficiaries receiving coverage through the group health plan may continue to receive such coverage from the plan and the Secretary may make payments to such plans, subject to the requirements of this section.

(b) REQUIREMENTS.—To receive payment under this section, group health plans shall—

(1) comply with certain requirements of this Act and other reasonable, necessary, and related requirements that are needed to administer this section, as determined by the Secretary;

(2) to the extent that there is a contractual obligation to provide drug coverage to retirees that is equal to or greater than the drug coverage provided under this Act, reimburse or otherwise arrange to compensate beneficiaries during the life of the contract for the portion of the part B premium under section 1839 of the Social Security Act that is identified by the Secretary of Health and Human Services as attributable to the drug coverage provided

under section 1849 of that Act (as added by section 3); or

(3) for group health plans that are in existence prior to enactment of this section and provide drug coverage to retirees that is equal to or greater than the drug coverage provided under section 1849 of the Social Security Act (as added by section 3), reimburse or otherwise arrange to compensate beneficiaries for the portion of the part B premium under section 1839 of the Social Security Act that is identified by the Secretary of Health and Human Services as attributable to the drug coverage provided under section 1849 of that Act (as added by section 3) for at least 1 year from the date that the group health plan begins participation under this section.

(c) PAYMENTS.—The Secretary shall establish a process to provide payments to eligible group health plans under this section on behalf of enrolled beneficiaries. Such payments shall not exceed the amount that would otherwise be paid to a private entity serving similar beneficiaries in the same service area under section 1849 of the Social Security Act (as added by section 3).

SEC. 5. MEDIGAP REVISIONS.

(a) REQUIRED COVERAGE OF COVERED OUTPATIENT DRUGS.—Section 1882(p)(2)(B) of the Social Security Act (42 U.S.C. 1395ss(p)(2)(B)) is amended by inserting before ''and'' at the end the following: ''including a requirement that an appropriate number of policies provide coverage of drugs which compliments but does not duplicate the drug benefits that beneficiaries are otherwise entitled to under this title (with the Secretary and the National Association of Insurance Commissioners determining the appropriate level of drug benefits that each benefit package must provide and ensuring that policies providing such coverage remain affordable for beneficiaries);''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on July 1, 2000.

(c) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the amendments made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as subsequently modified) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section; or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section; but

(ii) having a legislature which is not scheduled to meet in 2000 in a legislative session in which such legislation may be considered;

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 2000. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be

deemed to be a separate regular session of the State legislature.

SEC. 6. IMPROVED MEDICAID ASSISTANCE FOR LOW-INCOME INDIVIDUALS.

(a) INCREASE IN SLMB ELIGIBILITY TO 135 PERCENT OF POVERTY LEVEL.—.

(1) IN GENERAL.—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

(A) in clause (iii), by striking ''and 120 percent in 1995 and years thereafter'' and inserting '', 120 percent in 1995 and through July 1, 2000, and 135 percent for subsequent periods''; and

(B) in clause (iv)—

(i) by striking the dash and all that follows through ''(II)'', and

(ii) by striking ''who would be described in subclause (I) if '135 percent' and '175 percent' were substituted for '120 percent' and '135 percent' respectively'' and inserting ''who would be described in clause (iii) but for the fact that their income exceeds 135 percent, but is less than 175 percent, of the official pov-

erty line (referred to in such clause) for a family of the size involved''.

(2) CONFORMING AMENDMENT.—Section 1933(c)(2)(A) of such Act (42 U.S.C. 1396v(c)(2)(A)) is amended by striking ''the sum'' and all that follows and inserting ''the total number of individuals described in section 1902(a)(10)(E)(iv) in the State; to''.

(b) PROVISION OF MEDICAID PRESCRIPTION DRUG BENEFITS FOR QMBS AND SLMBS AS WRAP-AROUND BENEFIT.—

(1) IN GENERAL.—Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended—

(A) in subparagraph (E)(i), by inserting ''and for prescribed drugs (in the same amount, duration, and scope as for individuals described in subparagraph (A)(i))'' after ''1905(p)(3))'';

(B) in subparagraph (E)(iii), by inserting ''and for prescribed drugs (in the same amount, duration, and scope as for individuals described in subparagraph (A)(i))'' after ''section 1905(p)(3)(A)(ii)''; and

(C) in the clause (VIII) following subparagraph (F), by inserting ''and to medical assist-

ance for prescribed drugs described in subparagraph (E)(i)'' after ''1905(p)(3))''.

(2) CONFORMING AMENDMENT.—Section 1916(a) of such Act (42 U.S.C. 1396o(a)) is amended, in the matter before paragraph (1), by striking ''(E)(i)'' and inserting ''(E)''.

(c) EFFECTIVE DATES.—

(1) The amendments made by subsections (a)(1) and (b) take effect on July 1, 2000, and apply to prescribed drugs furnished on or after such date.

(2) The amendment made by subsection (a)(2) applies to the allocation for the portion of fiscal year 2000 that occurs on or after July 1, 2000, and to the allocation for subsequent fiscal years.

(3) The amendments made by this section apply without regard to whether or not regulations to implement such amendments are promulgated by July 1, 2000.

SEC. 7. WAIVER OF ADDITIONAL PORTION OF PART B PREMIUM FOR CERTAIN MEDICARE BENEFICIARIES HAVING ACTUARIALLY EQUIVALENT COVERAGE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a method under which the

portion of the part B premium under section 1839 of the Social Security Act that is identified by the Secretary of Health and Human Services as attributable to the drug coverage provided under section 1849 of that Act (as added by section 3) is waived (and not collected) for any individual enrolled under part B of title XVIII of the Social Security Act who demonstrates that the individual has drug coverage that is actuarially equivalent to the coverage provided under that part.

(b) LIMITATION.—Subsection (a) shall not apply to an individual with coverage through a group health plan if the group health plan receives payments for such individual pursuant to section 4.

SEC. 8. ELIMINATION OF TIME LIMITATION ON MEDICARE BENEFITS FOR IMMUNOSUPPRESSIVE DRUGS.

(a) REVISION.—

(1) IN GENERAL.—Section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)) is amended by striking ", but only" and all that follows up to the semicolon at the end.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs furnished on or after the date of enactment of this Act.

(b) EXTENSION OF CERTAIN SECONDARY PAYER REQUIREMENTS.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following: ''With regard to immunosuppressive drugs furnished on or after the date of enactment of the Medicare Prescription Drug Benefit Act of 1999, this subparagraph shall be applied without regard to any time limitation.''.

SEC. 9. EXPANSION OF MEMBERSHIP OF MEDPAC TO 19.

(a) IN GENERAL.—Section 1805(c) of the Social Security Act (42 U.S.C. 1395b–6(c)), as amended by section 5202 of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277), is amended—

(1) in paragraph (1), by striking ''17'' and inserting ''19''; and

(2) in paragraph (2)(B), by inserting ''experts in the area of pharmacology and prescription drug benefit programs,'' after ''other health professionals,''.

(b) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(1) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–

6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under subsection (a)(1) are as follows:

(A) One member shall be appointed for 1 year.

(B) One member shall be appointed for 2 years.

(2) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2000.

SEC. 10. GAO STUDY AND REPORT TO CONGRESS.

(a) STUDY.—The Comptroller General of the United States shall conduct a study and analysis of the implementation of the competitive bidding process for covered outpatient drugs under section 1849 of the Social Security Act (as added by section 3), including an analysis of—

(1) the reduction of hospital visits (or lengths of such visits) by beneficiaries as a result of providing coverage of covered outpatient drugs under such section;

(2) prices paid by the medicare program relative to comparable private and public sector programs; and

(3) any other savings to the medicare program as a result of—

(A) such coverage; and

(B) the education and counseling provisions of section 1849(g).

(b) REPORT.—Not later than January 1, 2001, and annually thereafter, the Comptroller General of the United States shall submit a report to Congress on the study and analysis conducted pursuant to subsection (a), and shall include in the report such recommendations regarding the coverage of covered outpatient drugs under the medicare program as the Comptroller General determines to be appropriate.

SEC. 11. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this Act apply to items and services furnished on or after July 1, 2000.

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